DOCUMENT RESUME

ED 464 733 PS 030 353

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TITLE	Supplementary Information To Accompany America's Child Care Problem: The Way Out.
INSTITUTION	Foundation for Child Development, New York, NY.
PUB DATE	2002-00-00
NOTE	27p.; For "America's Child Care Problem: The Way Out," see ED 459 009.
AVAILABLE FROM	Foundation for Child Development, 145 East 32nd Street, 14th Floor, New York, NY 10016-6055. Tel: 212-213-8337; Fax: 212-213-5897; Web site: http://www.ffcd.org. For full text: http://www.fcd.org/wp helburnbergmann.pdf.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Accreditation (Institutions); Caregiver Training; Child Health; Child Safety; Comparative Analysis; *Day Care; Day Care Centers; Day Care Effects; *Disabilities; Early Childhood Education; Family Day Care; Public Policy; Social Change; Special Needs Students; Teacher Education Programs
IDENTIFIERS	Caregiver Qualifications; *Day Care Quality; Project Head Start

ABSTRACT

This document provides supplementary information to accompany the Foundation for Child Development--supported book "America's Child Care Problem: The Way Out," published by St. Martin's Press (2002), which provides an in-depth look at the child care industry, identifying crucial problems such as the quality of care. Presented in five parts, this unpublished companion document addresses the following topics: (1) "Care for Children with Special Needs"; (2) "Protecting Children's Health and Safety"; (3) "Comparison of Studies of Quality for Center, Head Start, and Family Child Care Programs"; (4) "Comparison of Child Care Accreditation Systems"; and (5) "Training Designs for Child Care Workers." Each part contains reference notes. (KB)

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SUPPLEMENTARY INFORMATION
TO ACCOMPANY
AMERICA S CHILD CARE PROBLEM: THE WAY OUT
by Suzanne Helburn and Barbara Bergmann
(Palgrave for St. Martin s Press, 2002)

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Care for Children with Special Needs

Thirty years ago, most schools did not enroll children with severe problems. Children born with severe disabilities used to be kept in institutions. Refinements in treatment and equipment have allowed more of these children to live at home, and thus have the possibility of going to school along with other children.[1] The ideal of integrating children with special needs into mainstream classrooms is now clearly agreed upon by both professionals and the public. Both typical and atypical children are considered to benefit from this policy.[2]

The Education of All Handicapped Children Act of 1975, amended in 1986 and renamed Individuals with Disabilities Education Act (IDEA), reinforced by the American with Disabilities Act (1990), require mainstreaming in public institutions and in private institutions that accept public support. We have, however, a long way to go in creating an effective service delivery system to promote the integration of children with disabilities. Special supplementary funds are appropriated for child care centers who take children with special needs, but funding is limited and most centers are wary of taking in these children.

No one knows just how many preschool children are disabled. Eleven percent of public school children received special education in 1993. That figure is expected to rise as more families take advantage of the services created by the federal legislation.[3] Learning disabilities accounted for half of these special problems. While there is not a lot of research, early intervention for developmentally disabled children seems to help them advance closer to the norm for their age group. At the same time new technology and better neonatal care are increasing the number of. Thus the number of children with special needs in child care will certainly increase.[4]

Special needs include mild retardation, autism, cerebral palsy, AIDS, blindness, or a need for braces or wheelchairs. For many children, their special requirements can be met by modest incremental teacher training. For others an additional staff member is needed. Similarly, some need no additional equipment while others need both special equipment and modifications in the building itself. The budget implications of integrating a special needs child vary widely. Inadequately trained personnel create another major barrier to achieving the mainstreaming goal.[5]

Among child care experts, there is concern that the usual criteria defining developmentally appropriate practice do not provide an adequate guide for planning and evaluating programs for young children with special needs.[6] Early childhood special education requires that interventions to help the child with special needs be

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[1]Herbert J. Cohen, "Child Care for Children with Special Needs," *Pediatrics* 94, no 8, Supplement, Proceedings of the International Conference on Child Day Care and Health: Science, Prevention, and Practice (December 1994) 1055-1059.

[2]Sandra S. Parrino and Stephen B. Thacker, "The Challenge of Day-Care Health among Children with Disabilities," part 2, *Pediatrics* 94, no. 8 (December 1994): 1052ff.

[3]National Center for Educational Statistics, T. Snyder, ed., *120 years of American Education: A Statistical Portrait* (Washington DC, NCES, 1993), 44, Table 12, as cited in Dana L. Terman, Mary B. Larner, Carol S. Stevenson, and Richard E. Behrman,"Special Education for Students with Disabilities: Analysis and Recommendations," *The Future of Children* 6, no. 1 (Spring 1996): 4.

[4]Herbert J. Cohen, Child Care for Children with Special Needs; Ann L. Riley, "Interagency Coordination: The key to Mainstreaming Children with Special Needs into Day Care,"part 2, *Pediatrics* 84, no. 8 (December 1994): 1059ff.

[5]Riley, Interagency Coordination: The Key to Mainstreaming.

[6]Jane B. Atwitter, Judith J. Carta, Ilene S. Schwartz, and Scott R. McConnell, "Blending Developmentally Appropriate Practice and Early Childhood Special Education," in Bruce L. Mallory and Rebecca S. Now, *Diversity and developmentally Appropriate Practice for Early Childhood Education* (New York and London: Teachers College Press, 1994), 185-201, specifically 186.

embedded in classroom activities and routines. Special arrangements to promote active engagement of the child with a disability should intrude on regular classroom practice as little as possible. For instance, the teacher should be careful to choose games that all the children can participate in, regardless of handicap. The blind child's enjoyment of a read-aloud story about the seashore is enriched by feeling some sand and some water. More attention to orderliness in the classroom is required by children in wheel chairs, and toys may need to be rearranged for accessibility. For children with severe language impairment, teachers need to make more use of nouns than verbs since they are far easier for these children to learn.[7]

Securing appropriate child care for preschool special-needs children requires coordination among a diverse group of service providers - medical personnel, educational administrators, community and state child care agencies, state social service and welfare agencies and professional organizations of child care givers. Coordination at the state level among all of these is clearly called for, but is just beginning to happen.[8]

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[7]Alice Sterling Honig, "Creating Integrated Environments for Young Children with Special Needs," *Early Childhood Education Journal* 25, no. 2 (1997): 93-100.

[8]Carolina Policy Studies Program, *The Study of Federal Policy Implementation: Infants/Toddlers With Disabilities and Their Families* (Chapel Hill, NC, no date), 4; also Atwitter, et al., "Blending Developmentally Appropriate Practice, 196.

Protecting Children s Health and Safety

Young children are prone to injuries and infectious disease, and the providers of care need to be held to high standards of safety and sanitation to minimize their occurrence. Children are generally less likely to be injured in a child care center than they are in family child care, or in their own home. Centers can provide opportunities for health and safety education for the children and their parents, can motivate parents to get their children immunized, and have a chance to spot and report abuse. However, in a center, children s exposure to disease is greater than at home or in family child care.

The more young children are crowded together, the more opportunity there is for diseases to spread, and the younger the children, the more serious the problem. The American Public Health Association and the American Academy of Pediatrics have collaborated in the development of guidlines to minimize infection.[1] However, child care centers and family care providers vary widely in their compliance with them. Young children, especially those less than 2 years old are much more susceptible to a variety of infectious diseases, have less ability to control their personal hygiene, and in child care centers are in close contact with many more sources of infection. Many of their diseases are infectious before the symptoms are evident, making it difficult or impossible to segregate the sources of infection. Transmission may occur from person-to-person by the fecal-oral route, by contact with skin and excretions, and by aerosols and respiratory droplets.[2] It is not surprising, then, that children in child care have more illnesses than children reared at home for the first two years of life. The differences, however, disappear by age three and a recent NICHD study from the Early Child Care Research Network reports that these illnesses do not affect children s development, except for possible increases in behavior problems.[3]

Outbreaks of diarrhea have been found to occur in child care centers as often as 3 times a year, with children suffering as many as 4 cases a year. This is from one and one half to three and a half times as often as in home care.[4] Diarrhea in family day care is thought to be only slightly more frequent than in home care. One reason for such low quality scores for infant and toddler rooms observed in the CQO study was the failure to follow diapering rules. In an extensive study in North Carolina, fecal matter was found on well over half the hands of both staff and children and over a third of classroom sinks, faucets and toys.[5] The likelihood of a spread of disease is increased when the same staff person is responsible for both personal sanitation and for preparation and serving of meals.

We are all familiar with the runny noses reflecting what the health professionals call upper respiratory diseases . These are the most common problem in child care centers. In one study of acute respiratory illness, infants 12 months old or less were found to be afflicted on average nine times a year. Frequency of such infections decreases with age, falling to an average of 3.3 cases per year for 4 year olds. While most cases are relatively mild,

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[1] American Public Health Association, American Academy of Pediatrics, *Caring for our Children - National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care* (Washington DC: American Public Health Association and the American Academy of Pediatrics, 1992). This document covers all areas of health and safety. It is currently under revision. For a useful literature review completed in connection with the revision see Richard Fiene, *National Resource Center for Health and Safety in Child Care Key Indicator Research Brief* (State College PA: Capital Area Early Childhood Training Institute, Pennsylvania State University, December 2000).

[2] Stephen B. Thacker et al., "Infectious Diseases and Injuries in Child Day Car: Opportunities for Healthier Children," *Journal of the American Medical Association* 268, no. 13 (October 7, 1992): 720-1726.

[3] NICHD Early Child Care Research Network, Child Care and Common Communicable Illnesses: Results from the NICHD Study of Early Child Care, *Archives of Pediatrics and Adolescent Medicine* (in press).

[4] Ibid.

[5] Danielle J. Laborde et al., The Frequency, Level, and distribution of Fecal Contamination in Day Care Classrooms, part 2, *Pediatrics* 94, no. 8 Supplement, Proceedings of the International Conference on Child Day Care and Health: Science, Prevention, and Practice (December 1994): 1008-1011.

many are accompanied by acute otitis media (middle ear infection). Repeated ear infections can have serious developmental consequences and can lead to further medical and surgical treatments. Risk of repeated infections is much higher in group day care than in home care.[6]

As of 1994, 32 states licensed out-of-home programs specifically for mildly sick children, presumably those who would be excluded by their regular caregiver. Usually operated by nurses, these centers seem to be effective in decreasing contagion. Repeat use by families suggests that families were pleased with the service. Average cost of the surveyed programs was $38 per day, with the parent's employer paying 64% of the cost. However,"get-well care" within the child's regular care environment may be optimal, if cost-effective procedures can be developed to limit contagion, enhance the child's recovery, and assure safe but affordable care.[7]

Injury is the most common cause of disability and death to children.[8] The last 25 years have seen marked progress in the reduction of childhood infections, but there has been little change in childhood deaths from injuries. Approximately 25% of children annually incur injuries requiring medical care.[9] In contrast to disease, injuries, including burns and poisonings, are more common in homes than in centers.[10] One study of almost 1,200 children in an HMO showed injuries in day care of 2.5 per 100,000 child-hours compared with 4.9 per 100,000 child-hours of exposure at home.[11] In a large national study of 1797 centers, the injury rate was 1.5 per 100,000 child-hours in child care, with over half of the serious injuries due to falls from climbing equipment.[12] Falls represent the major cause of injury: 38 percent in centers and 48 percent at home. "Hit by another child" and "play" each represent 21 percent of the cases in centers, but only 1 and 8 percent, respectively, at home. Biting is an under recognized problem. Almost half of the children enrolled in one day care center were bitten during a 12 month period.[13] Injury rates vary widely from center to center.

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[6] J. P. Collet et al., "Type of Day-care Setting and Risk of Repeated Infections," part 2, *Pediatrics* 94, no. 8 (December 1994): 997ff. However, a recent study found children in family child care homes had more illness than children in large group homes. See J. St. Sauver, M. Khurana, A. Kao, and B. Foxman, Hygienic Practices and Acute Respiratory Illnesses in Family and Group Day Care Homes, *Public Health Reports* 113, no. 6 (1998): 544-51.

[7] Scott G. Giebink et al., "Care of Mildly Ill Children in the Day-Care Setting," part 2, *Pediatrics* 94, no. 8 (December 1994): 1024-1026. They also recommended more options for parents to care for their ill children at home.

[8] Frederick P. Rivara and Jeffrey J Sacks, Injuries in Child Day Care: An Overview, part 2, *Pediatrics* 94, no. 8 (December 1994): 1031-1033.

[9] Ibid.

[10] W. J. Gunn, P. F. Pinsky, J. J. Sacks, and L. B. Schonberger, Injuries and Poisonings in Out-of-Home Child Care and Home Care, *American Journal of Diseases of Children* 145, no. 7(1991): 779-781.

[11] In this study, injuries were reported for in two groups: home care and day care. The former were injuries to children cared for in their own home, or in family child care enrolling four or fewer children. The latter were injuries to children cared for in facilities enrolling more than four children, which included center care and larger family child care homes. Frederick P. Rivara, Carolyn Di Guiseppi, Robert S. Thompson, and Ned Calonge, Risk of Injury to Children Less than 5 years of Age in Day Care Versus Home Care Settings, *Pediatrics* 84, no. 6 (December 1989):1011-1016.

[12] Peter A. Briss, Jeffrey J. Sacks, David G. Addiss, Marcie-jo Kresnow, and Joann O Neil, A Nationwide Study of the risk of Injury Associated with Day Care Attendance, *Pediatrics* 93, no. 3 (1994): 364-368.

[13] J. Garrard, N. Leland, and D. K. Smith, "Epidemiology of Human Biting to Children In a Day Care Center," *American Journal of Diseases of Children* 142 (1988): 643-650, as cited in Thacker et al., "Infectious Diseases and Injuries.

Children are safer from abuse and neglect in centers than they are in family child care, or in their own homes. In a national survey of licensing and child protection officials and clinicians authors estimated an annual rate of 5.5 sexually abused children for children under six years old per 10,000 enrolled in day-care centers (not family day-care homes), a rate lower than national figures of 8.9 per 10,000 for children in families".[14] Although there is a lower incidence of child abuse in centers, the effects on the children of such abuse can be more serious than in home care. Physical abuse most often occurs as a result of over discipline, more often at the hands of males, often in response to prior conflicts with the child. Furthermore, researchers report concern about the failure of center staff to report suspicion of abuse by fellow staff and parents.[15]

In thinking how to improve the health and safety of children in child care, it is obvious that better sanitation is of the highest priority. More frequent and more thorough hand washing can do more to prevent the spread of disease than any other single improvement.[16] Disinfecting toys, furniture, sinks, and faucets will help as well. Training of both staff and children is effective, but it must be repeated continually and the recommended procedures must be enforced. High turnover rates in infant and toddler rooms, and disillusionment with a job composed mainly of feeding babies and changing dozens of diapers a day make training and enforcement more difficult. But it should be possible to train aides to use rubber gloves and change them after each diapering (dental hygienists seem to handle this with ease).

Inadequate staffing and inappropriate facilities make improvement difficult. If a caregiver has too many infants to take care of, hand washing is sacrificed. Inconvenient location of sinks have the same result. Too many children per adult reduces supervision and results in more frequent injuries. A gate left open so that a child wanders into the street can only be prevented by careful adult behavior.

The risk of child abuse can be reduced by providing staff in centers with adequate support and a model of care that focuses on positive behavior. When staff are fully supported and are satisfied with their role as child care workers they are less likely to be abusive. Also, providers need to be able to recognize abuse and know what to do about it.[17]

Many diseases have been reduced by appropriate vaccinations. Diphtheria, Haemophilus influenzae , Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Congenital Rubella Syndrome and Tetanus. Continued vigilant enforcement of laws requiring licensed child care centers to require vaccinations will be needed. Education of parents and providers would be useful. Vaccinations should be expanded to include Hib disease, the most common cause of bacterial meningititis, and the influenza virus.[18]

Proper design and maintenance of the building and the playground goes a long way toward reducing injuries: Smoke detectors, cooler tap water, separate kitchen areas, complete fencing of pools and playgrounds, hazard free playground equipment of limited height and energy absorbing material beneath playground equipment. The last two are worth some emphasis as head injuries from falls are a major risk that has not been adequately

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[14] Thacker et al., Infectious Diseases and Injuries, 1725f.

[15] Leslie Margolin, Abuse and Neglect in Non Parental Child Care: A Risk Assessment, *Journal of Marriage and the Family* 53, no. 3(1991): 694-704; Ruth B. Schumacher and Rebecca S. Carlson, Variables and Risk Factors Associated with Child Abuse in Day Care Settings, *Child Abuse and Neglect* 23, no. 9(1999): 891-898.

[16] J. P. Niffenegger, Proper Handwashing Promotes Wellness in Child Care , *Journal of Pediatric Health Care* 11, no. 1(1997).

[17] D. L. Daly and T. P. Dowd, Characteristics of Effective, Harm-Free Environments for Children in Out-of-Home Care, *Child Welfare* (November-December 1992): 487-496.

[18] Elaine E Schulte, Guthrie S. Birkhead, Stanley F. Kondracki, and Dale L. Morse, Patterns of Haemophilus Influenzae Type b Invasive Disease in New York State, 1987-1981; The Role of Vaccination Requirements for Day Care Attendance, part 2, *Pediatrics* 94, no. 8 (1994): 1014-1016.

addressed by most state regulations nor by child care centers.[19] As of 1994, no state limited the height of playground equipment and two thirds of the states did not even mention the need for resilient padding under playground equipment.[20]

The additional cost of improved vaccinations, sanitation and reduced risk of injury must be balanced against the benefits of better health of the children, the care givers, their families and the community. In addition to medicines, hospitals, doctors and the like, parents miss between one and 4 weeks of work per year because of sick children.[21] A Memphis, Tennessee study of 843 children in a prepaid health plan found that the mean monthly cost of medical care was $32.94 for children in centers, and $19.78 for children in relative and day-care homes.[22]

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[19] Peter A. Briss, Jeffrey J. Sacks, David G. Addis, Marcie-Jo Kresnow, and Joann O Neill, Injuries from Falls on Playgrounds, Effects of Day Care Regulation and Enforcement, *Archives of Pediatrics and Adolescent Medicine* 149, no. 8 (1995).

[20] Letty Lie, Carol W. Runyan, Eleni Petridou, and Albert Chang, American Public Health Association/American academy of Pediatrics Injury Prevention Standards, *Pediatrics* 94, no. 8 (1994): 1046-1048.

[21] Jeffrey P. Davis, William R. MacKenzie, and David G. Addis, Recognition, Investigation, and Control of Communicable-Disease Outbreaks in Child Day-Care Settings, *Pediatrics* 94, no. 8 (1994): 1004-1006.

[22] David M. Bell, Dennis W. Gleiber, Alice Atkins Mercer, Robi Phifer, Robert H. Guinter, A. Jay Cohen, Eugene U. Epstein and Manoj Narayanan, "Illness Associated with Child Care: A Study of incidence and Cost," *American Journal of Public Health* 79, No. 4 (April 1989): 479.

Comparison of Studies of Center, Head Start, and Family Child Care Quality

Study	Sample Description	Measurement Instruments	Results - Level of Quality	Results - Predictors of Quality
Center Child Care				
National Child Care Staffing Study Whitebook, Howes, & Phillips, 1990	stratified random sample of 3 randomly selected classes (infant, toddler, preschool) in 227 centers in Atlanta, Boston, Detroit, Phoenix, Seattle; 17% in low-income census tracts. 3 samples of 414 children 14-54 months old from Atlanta and LA centers.	ECERS, ITERS, Arnett Caregiver Interaction Scale; measures of child s attachment, peer play	Ave ECERS Scores: Infant Preschool Develop Appropriate 3.2 3.6 Appropriate care giving 4.2 4.4 On developmentally appropriate activities only 12% had good quality and 33% had poor quality. Higher scores in Boston than in Phoenix & Atlanta centers, in nonprofits than in for-profits, in accredited than in nonaccredited Teaching staff ave hrly wage = $5.35; 57% earned $5/hour or less. Staff turnover 41%/yr.	Amount of formal ed best predictor of appropriate teacher behavior (only college level ed associated with effective teaching), specialized training important for infants. Children in centers with high turnover spent less time in social activities and more time in aimless wandering. Higher wages associated with developmentally appropriate activities, lower ratios, lower turnover.
Child Care and Family Study Scarr, Phillips, McCartney, Abbot-Shim, 1993	stratified random sample of 120 centers with <30% subsidized children in MA, VA, GA; 720 children: 2 children in 3 classes/ctr (infant, toddler, preschool)	ECERS, ITERS, measures of child and teacher social behavior	% with poor quality infant rooms: 77% in GA, 84% VA, 23% MA. % with poor quality preschool rooms: 39% GA, 20% VA, none MA. Almost _ of VA centers and 1/3 of MA centers violated licensing ratios in infant/toddler rooms. Lower quality in church & for-profit in GA infant rooms.	Based on hierarchical regressions including education, ratios, group size: highest wage the center pays to teachers was the strongest predictor of quality; staff training important in toddler rooms. Higher wages related to higher fees and turnover.
Cost, Quality, & Child Outcomes in Child Care Centers Helburn, ed, 1995	Stratified random sample of 401 centers in CA, CO, CT, NC, 50 nonprofit, 50 for-profit in each state, 521 preschool and 228 infant/toddler classes, 2 children per class. 826 children in outcomes study at 4 years old, end of kindergarten, end of grade 2	ECERS, ITERS, Arnett Caregiver Interaction Scale, Howes Teacher Involvement Scale, Peer Play Scale. Longitudinal testing of children s language and pre-math skills.	Ave ECERS Scores: Inf/tod Preschool Develop Appropriate 3.3 3.8 Appropriate care giving 4.1 4.4 Health 2.5 14% centers had good quality, 12% had poor. Infant rooms: only 8% good 40% poor quality, lower quality in NC for-profit than nonprofits. Higher scores in accredit. 40% turnover, ave hrly wage teaching staff = $6.89	Based on estimation of quality production function: ratio most important determinant of quality, also turnover, % staff with BA, tenure of director, director s support of teachers. Negatively related: existence of bilingual program, b&a school program, church auspice, CA for-profit, NC for-profit.
Florida Child Care Quality Improvement Study (effect of improved infant todd ratio standards and requirement of CDA teacher training): Howes, Smith, & Galinsky, 1998	stratified random sample of 150 licensed centers in 4 Florida counties, 40% with >50% subsidized children, 450 classes (infant, todd, preschool); 880 children - at 3 time periods before and during changes in regulation: 1992, 1994, 1996	ECERS, ITERS, Arnett Caregiver Interaction, Howes Teacher Involvement, other teacher behaviors. Measures of children s attachment, peer play, object play, language use, behavior problems	1992 ave scores: ITERS = 3.9, ECERS = 4.3. By 1996 nonsignificant increases and no significant change in teacher sensitivity. Children s level of peer play, object play , attachment security improved: 96>94>92. Lack of quality improvement over time probably due to smaller % of centers in compliance with regulations in 1996.	Global process quality, teacher sensitivity and responsiveness higher in centers complying with FL ratio, and with CDA training; higher still in centers complying with more demanding professional ratio stds, highest when teachers have a B.A. No trade-off between teacher education and ratio.

Study	Sample Description	Measurement Instruments	Results - Level of Quality	Results - Predictors of Quality
The NICHD Study of Early Child Care. NICHD Early Child Care Research Network, Characteristics and Quality of Child Care for Toddlers and Preschoolers, 1998 The only study to compare quality across types of providers	1216 children from 10 U.S. locations born in 1991. From all women giving birth in each sampling period, screened to exclude 9 categories of mothers, a conditional random sample of mothers and children were drawn. Child care providers are those caring for these children. Data collected when children were 6, 15, 24 and 36 months old.	Many observation procedures and instruments used. For quality studies: (1) ORCE (Observational Record of the Caregiving Environment) to record the frequency of specific behaviors and make qualitative ratings of positive caregiver s behavior. (2) Global rating, overall common sense evaluation of the quality of care in the setting.	Fathers, grandparents, in-home caregivers provided more positive caregiving and a higher frequency of caregiving than family child care providers who received higher ratings than centers. But positive caregiving depends both on type of care and child-adult ratio at different ages of children. At 36 mos. ratings were the same across all types of care and ratios. Most common category of positive care-giving was somewhat uncharacteristic (42% at 15 mos., 50% at 24 mos., 58% at 36 mos.)	In regression analysis positive caregiving related to more child-centered beliefs of caregivers, their level of education and experience (at 24 mos.) and more specialized training (at 15 mos.). Lower child-adult ratios more important for in-home caregivers than for centers. Addition of physical learning environment significantly improved prediction of positive caregiving in centers and family child care homes.
FACES (Head Start Family and Child Experiences Survey). Zill, Resnick, McKey, Clark, Connell, Swartz, O Brien, E Elio, Head Start Performance Measures Second Progress Report (1998)	Nationlly representative sample of 40 Head Start Programs, 156 centers, 403 classrooms of 3-5 year-old children, 2400 children	ECERS, Arnett, Assessment Profile Scheduling Scale, Assessment Profile Learning Environment Scale, Peabody Picture Inventory, Woodcock Johnson, social scales	Ave ECERS=4.9, std dev. = 6. Distribution: 1 to <2.5 0% 2.5 to <3.5 1.5 3.5 to <4.5 20.0 4.5 to <5.5 61.5 5.50 and above 17.0	33% teachers had a B.A. or more, 25% had some college. Staffing ratio 5.6:1

Study	Sample Description	Measurement Instruments	Results - Level of Quality	Results - Predictors of Quality
Family Child Care				
National Day Care Home Study. Divine-Hawkins, 1981	303 providers in L.A, Philadelphia, San Antonio Random selections for sponsored & regulated but not unregulated providers	Observation of caregiver s use of time (types of direct and indirect interaction with children & noninvolvement), caregiver affect	Family day care homes positive environments for children. Little negative affect. Caregiver spent 46% of time in direct interaction with children: 14% in teaching, 8% in play participating, 9% helping, 3% conversing, totally uninvolved 33% of the time, out of observable rang 1.3% of time. Unregulated less involved, sponsored homes more involved and more teaching.	Training showed widespread positive relationships to caregiver behavior, experience almost no relationship, education only within the Hispanic population. More frequent behavior with training: language used to inform, structured fine motor activities, music, dramatic play, teaching helping. In unregulated homes more comforting and positive affect. In homes with caregiver s child present and in relative care, fewer child-centered activities and less structured activities.
The Study of Children in Family Child Care & Relative Care. Kontos, Howes, Shinn & Galinsky 1995	From random digit dialing, lists of families with young children, & birth records 226 providers in L.A., Dallas Ft Worth, Charlotte; 112 regulated, 54 unregulated, 50 relative.	FDCRS, Arnett Caregiver Interaction Scale, Howes Teacher Involvement Scale.	9% rated as good quality, 56% ade-quate/custodial, 35% poor. Poor and minority children in lower quality. Better quality from regulated, professional, businesslike providers caring for a larger number of children.	Quality better when providers are committed to family child care as a profession, have more education, participate in family child care training, are regulated, are involved in professional groups, care for larger numbers of children, are more business-like.
Howes and Norris. Adding Two School Age Children: Does It Change Quality in Family Child Care? *Early Childhood Research Quarterly*, 1997	100 randomly selected licensed family child care providers in Southern California, 81 licensed for 6 children, the remainder for 12, observed in December, 1993, 28 providers with additional children observed again in the fall of 1994.	FDCRS, Arnett Caregiver Interaction Scale. A specially constructed measure of 4 provider activities: disciplining, cuddling, book reading, providing arts & crafts. Also measured extent to which infants & toddlers were unoccupied or restricted.	Mean FDCRS = 3.81 Poor (< 3) 23% Adequate (3 to 5) 67 Good (5 or >) 10 Major change in children s experiences after additional school aged children added was a decrease in provider sensitivity. With additional children most provides shifted focus from developmental needs of younger children to needs of older children. Little evidence of older children taking care of younger ones, but younger children joined in when older children engaged in phantasy play or arts & crafts.	

Detailed Comparison of Accreditation Systems.

In addition to the NAEYC, six other national organizations have developed accrediting programs:

- The Council on Accreditation of Services for Families and Children, Inc.(COA)
- The National Child Care Association (NCCA), the trade association of the for-profit companies
- The Preschool Accreditation Program of the Association of Christian
- Schools International (ACSI)
- The Ecumenical Child Care Network (ECCN) of the National Council of Churches in Christ (in cooperation with the NAEYC).
- National Association of Family Child Care
- National School-Age Care Alliance

Table 1 compares the accreditation process and quality criteria developed by the seven accrediting agencies. Most of the agencies follow a similar accreditation process. Most include similar program characteristics in establishing their criteria for accreditation. Table 1 shows considerable uniformity in approach and content, but the apparent similarities hide differences in general orientation, emphasis, and attention to detail. Big differences exist, for instance, in structural quality standards as shown in Table 2. Most of the accrediting agencies require lower standards for staffing ratios, group size, teacher education qualifications and inservice training than recommended in *Stepping Stones to Using Caring for Our Children* .

The Council on Accreditation of Services for Families and Children, Inc.(COA) accredits a wide range of health, child, and family social services agencies, including child care providers, that receive funding from private philanthropies such as United Way as well as from state and local governments.[1] It was the first organization to provide accreditation in child care, which developed partly in response to accountability needs of public and private funders of services. The impetus to accredit child care programs seems to have come from the Child Welfare League of America. As early as 1960 the League had developed standards for social welfare services for children. In 1977 the League helped sponsor the formation of COA.

COA serves a unique client group - large, multiple function social service agencies that include child care centers, family day care and group homes. Since a higher proportion of children served come from families needing social services, COA criteria emphasize the accessability of social services, family involvement, parent education, and delivery of more comprehensive services. Accreditation standards also require programs to attend to the developmental and educational needs of each child. However, these parts of the COA self-study manual do not provide much detail and direction to center staff, and evidence of compliance relies mainly on written descriptions and interviews, not on classroom observation. Thus, the self-study and validation process give inadequate attention to the quality of services provided. This may be offset, however, by greater attention to management and organization and higher structural quality requirements: lower child:staff ratios and higher staff education qualifications than recommended by NAEYC.

The National Early Childhood Program Accreditation (NECPA), was created by the National Child Care Association (NCCA), a trade association of mainly for-profit independent centers, to provide a more user friendly alternative to NAEYC accreditation. The system is based on the "Key Indicator" approach that was originally developed to streamline the monitoring of licensing compliance by using a short list of key regulatory indicators to predict overall compliance.[2] To apply this procedure to accreditation a set of key indicators was statistically identified from NAEYC and *First Steps* criteria. Pilot study results comparing the two evaluation instruments

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[1] Council on Accreditation of Services for Families and Children, *1997 Self-Study Manual for Behavioral Health Care Services and Community Support and Education Services* vol 1 and 2, United States Edition (New York: Council on Accreditation of Services for Families and Children, Inc.).

[2] The key indicator approach has been developed by Richard Feine for NECPA. For an introduction to the approach, see Richard Fiene and Karen Kroh, Measurement in Licensing and Regulatory Administration, in *National Association for Regulatory Administration Curriculum*, Chapter 7 (St Paul MN: National Association for Regulatory Administration, 1997).

showed that the key indicators predicted compliance with all the NAEYC/*First Steps* criteria. That is, the indicator checklist items, taken as a whole, predicted whether or not a center qualified for accreditation based on the more comprehensive standards, indicating that the key indicator approach can be used to determine compliance with accreditation standards.[3]

NCCA has designed its accreditation system around the key indicator approach. It uses the key indicators as core accreditation standards and has designed the self-study manual around the indicator checklist.[4] The manual converts the indicators into a self-evaluation questionnaire and classroom observation instrument composed of straight forward questions requiring a yes or no answer. This self-study is relatively simple to use compared to the NAEYC self-study which requires staff to evaluate more program aspects, write more detailed responses and base program characteristic evaluations on a rating system (not simple yes no responses). The NCCA encourages but does not require staff to use the checklist for self-evaluation. The external evaluator verifies the center self-study responses based on examination of center documents and classroom observation. NCCA claims that a center that receives yes on all items in the checklist from the external reviewer would also meet the comprehensive criteria for accreditation used by NAEYC.[5]

The key indicator system of accreditation has promise in reducing the costs of accreditation, but it should be used primarily for external validation of a program, not to simplify the self-study process. To claim that centers accredited by NCCA have comparable quality to those accredited by NAEYC, the self-study process needs to be based on all the NAEYC criteria, requiring a time-consuming self-study process similar to the NAEYC procedure. Furthermore, to discourage centers from limiting their self-study process to quality aspects measured by the key indicators, the external validation should include a random sample of items from the comprehensive standards that the key indicators represent. NCCA has used the key indicator approach to create a simpler accreditation process for centers by restricting its standards and self-study to the key indicators. This does not seem legitimate if NCCA wants to claim that its accreditation procedures yield results comparable to NAEYC accreditation, because the external evaluation is no longer tied to the more comprehensive NAEYC and *Stepping Stones* criteria for accreditation.

NCCA literature implies that their system is more fully compatible with the health and safety criteria in *Stepping Stones to Using Caring for Our Children* than is the NAEYC system.[6] Indeed, standards for health protection and promotion, health and safety, building, supplies, equipment, and transportation are more detailed than the NAEYC standards. In contrast, however, the criteria on educational process, curriculum and staff-child interactions are relatively brief and the checklist items used to evaluate the developmental program emphasize organization of the physical space and availability of different kinds of learning opportunities. Fewer items involve child/staff interactions and the abilities of staff to work sensitively and intelligently with children to encourage their development. Combining *Stepping Stones* standards with the NAEYC standards seems to have the effect of emphasizing health and safety at the expense of curriculum and staff/child interactions. This may be appropriate in accrediting for-profit centers that need to emphasize quality characteristics that parents are most likely to care about. However, the criteria seem to stray from those considered most important by the ECE profession as a whole.

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[3] National Early Childhood Program Accreditation Commission, *National Early Childhood Program Accreditation, NECPA* (Conyers GA: The National Early Childhood Program Accreditation Commission, Inc., 1996).

[4] National Early Childhood Program Accreditation Commission, *The National Early Childhood Program Accreditation Standards: A Guide for Programs Seeking Accreditation* (Conyers, GA: National Early Childhood Program Accreditation Commission, Inc , 1998).

[5] Richard Fiene, Using a Statistical-Indicator Methodology for Accreditation, in Sue Bredekamp and Barbara Willer, eds., *NAEYC Accreditation: A Decade of Learning and the Years Ahead*, (Washington DC: National Association for the Education of Young Children 1996). The items are selected through estimating a coefficient that compares compliance the rule in high and low compliance facilities.

[6] NECPA Commission, *The National Early Childhood Program Accreditation Standards, 1998*, 5; See also, Health Resources and Services Administration, U.S. Department of Health and Human Services, *Stepping Stones to using Caring for our Children* (Denver CO: National Resource Center for Health and Safety in Child Care, University of Colorado Health Sciences Center 1997).

With respect to structural quality standards Table F-2 shows that staffing ratios and group size standards are, if anything a bit more stringent than those of NAEYC, but the NCCA teacher education qualifications are lower. NCCA requires only one teacher in the center to have at least a CDA certificate; other members of the teaching staff must have 30 clock hours of instruction within a year of being employed.

As with NAEYC accreditation decisions, NCCA allows commissioners some decision making discretion. Some key indicators are weighted more heavily than others, so that failure to comply to some less important indicators does not disqualify a program from receiving accreditation. In addition, commissioners can balance the center s score on the standardized part of the evaluation with unique aspects of a program that may justify accreditation. Unfortunately, the key indicator system approach requires 100% compliance to claim that the system predicts compliance with NAEYC/*Stepping Stones* criteria. In any event, for the reasons given above, it is doubtful that NCCA screening is as stringent as NAEYC screening. Since NCCA accreditation seems the most likely alternative to NAEYC accreditation, research is needed to clarify the relation between NAEYC and NCCA accreditation.

Accreditation by the Association of Christian Schools International (ASCI) emphasizes the religious aspect of the early childhood program, but it also embraces developmentally appropriate care and education.[7] Standards are quite specific in requiring a mix of materials, equipment, and activities that promote children s cognitive, physical and social development and meet children s individual needs. They also include guidance on staff-child interactions that promote children s social and emotional needs. However, the use of open-ended self-study questions gives little guidance to staff about specific, expected, observable behavior; and the information supplied as evidence of compliance does not include observation-based classroom evaluation. ASCI relies on state minimum licensing requirements as standards for structural quality such as square footage and staff training. Table F-2 shows that staffing and teacher training standards are well below those used by other accrediting agencies.

ASCI exerts more control over the self-study process than other accrediting agencies. An ACSI representative visits the center to establish eligibility and appoints a consultant to guide the self-study. The consultant helps form a steering committee to administer the process and eight committees, one for each section of the self-study. Each committee submits a report describing major strengths and needed improvements based on specific questions in the self-study manual. The process does not include parent surveys, and centers do not seem to be required to meet all the standards before becoming accredited.

The program operated by the Ecumenical Child Care Network (ECCN) focuses on an important precondition to creating good quality in churches and other places of worship that is not dealt with by NAEYC, relations between the center and its sponsoring congregation.[8] The quality of child care programs operated by religious groups can suffer from a number of organizational problems: if there is inadequate delineation of responsibility between the church and child care center, if the congregation does not see the child care center as part of the church ministry, if it does not understand the need for professional management of the center; if center finances are not separated from church finances (a serious problem if the congregation considers the center a source of income). The self study reminds the congregation of the relationship between their own religious mission and the care and development of children. The self study develop effective mechanisms for communication, coordination, financing, and administering the center. Completion of the self-study manual demonstrates that the center and the congregation have been in close communication and it documents the policies and contractual arrangements that have been put in place. In recognizing congregations that have developed a business-like relationship with their center, ECCN prepares these centers to undertake the NAEYC accreditation process.

The National Association of Family Child Care administers the family child care accreditation process which was revised in the late 1990's. The new family child care quality standards were developed through a two

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[7] Preschool Accreditation Program, *1998 ACSI Manual of School Accreditation: Evaluative Criteria* (Colorado Springs CO: Association of Christian Schools International).

[8] Dorothy Steele, Laura Friedrich, Marjorie Hampton, Nancy Peddle, Carolyn Van Donselaar, and Marcia Zeimes, *Congregations and Child Care: A Self-Study, 1996 Edition* (Chicago IL: The Ecumenical Child Care Network).

year consensus building process coordinated by the Family Child Care Accreditation Project at Wheelock College in collaboration with the National Association for Family Child Care. The accreditation procedure was piloted during 1998 in five diverse communities across the country, resulting in revisions of the final system.[9] The National School-Age Care Alliance (NSACA) administers accreditation for before-and-after- school programs. Several years of research and field testing went into establishing the NSACA standards that were adapted from earlier standards developed by the School-Age project at the National Institute on Out-of-School Time at Wellesley College s Center for Research on Women.[10]

[9] National Association for Family Child Care, *Quality Standards for NAFCC Accreditation Provider s Self-Study Workbook* (Des Moines, IA: National Association for Family Child Care Foundation, 1997).

[10] Janette Roman, ed., *The NSACA Standards for Quality School Age Care* (Boston MA: The National School-Age Care Alliance, 1998).

Table 1.
National Child Care Accreditation Programs: Procedures and Criteria

NAEYC Nation Academy of Early Childhood Programs (NAECP) of the NAEYC	NCCA National Early Child-hood Professional Accreditation (NECPA) of The NCCA, National Child Care Association	COA Council on Accreditation of Services for Families and Children	NCR National Council on Recognition of the ECCN, Ecumenical Child Care Network	ACSI Preschool Accreditation Program of the Association of Christian Schools International	NAFCC National Association of Family Child Care	NSACA National School-Age re Alliance
Procedure Classroom & admin self-study, staff & parent surveys Make improvements On-site self-study Validation visit Decision by 3-person Commission Annual report Loss of accreditation for inaccurate info	Self-evaluation on key indicators, parent & staff surveys On-site verification Submit package to NECPA National Accred. Council Key indicators scoring creation of center Profile Commission Decision Annual Report	Self-study using manual On-site evaluation by accreditation team Opportunity to re-view team report Decision by Accred itation Committee Appeals process Monitoring to assure compliance	Create self-study team from congre-gation & center Pre-test assessment of center-church relationship Pass post-test Submit documents to NCR *Optional*: complete NAEYC accred. Annual report	Candidate status visit to determine if center is eligible Self-study using manual guided by consultant of strengths/weaknesses On-site validation (1 or 2 days) Decision by Regional Accred. Commission Annual report	Self-evaluation to design professional development plan Participate in accred-itation training Complete 45 hr train Make quality improvements Parent survey Validation visit NAFCC decision	Review standards Form self-study team Make improvements Submit self-study Endorsement visit & recommendation NSACA decision Agree to continual compliance Complaint procedure
renewal every 3 yrs	every 3 years	every 3 years	every 3 years	no information	Every 3 years	no information

NAEYC	NCCA	COA	NCR	ACSI	NAFCC	NSACA
Criteria						
Interactions: children and teachers Curriculum: Developmentally approp balance Teacher family relations Staff qualifications, professional development Administration Staffing Physical environmnt Health and safety Nutrition and food Evaluation: strengths and weaknesses	Staff/child interactions and care Curriculum Developmental Prog Staff-parent-community partnering Staff qualifications and development Administration & staff relations Physical environment Buildings, supplies, equipment, transport Health & safety Health protection and promotion Child supervision and behavior management Program evaluation Infants and Toddlers	Access to service Availability of social services Parents are active participants Developmentally appropriate services Staff qualifications Adult-child ratios Health and safety Family Day Care supervision Child outcomes and program evaluation	Ministry - includes a child care mission Formal governance structure Administrative cooperation Liaison - communication and coordination Financial commitment and responsibilities	Philosophy & policy making body Administration - director responsibilities Family & community relations Staff qualifications - a personal relation with God, staffing, training Curriculum - DAP and meets spiritual needs of children Physical environment Health and safety Nutrition and food	Relationships with children & parents Home environment equipment/materials Activities: child directed provider directed Developmental learning goals Safety and health Professional and business practices	36 keys to quality: Human Relations Indoor Environment Outdoor Environmnt Activities Safety, Health & Nutrition Administration Staffing & group size, inservice training

Table 2.
Comparison of Staffing Ratio, Group Size, and Staff Training Requirements/Recommendations

Age-group	0-12 months	13-24 mos.	25-30 mos.	31-35 mos	3 years	4 & 5 years	education qualification	annual in-service ed.
	staff group ratio size	staff group ratio size	staff group ratio size	staff group ratio size	staff group ratio size	staff group ratio size	teachers	teaching staff
Stepping Stones	3:1 6	3:1 6	4:1 8	5:1 10	7:1 14	8:1 16	combo college course work & experience, pediatric first aid	yes, but not specified
NAEYC	3:4:1 6:8	3:5:1 6:8:10:12	4:6:1 8:10:12	5-7:1 10:12 14	7-10:1 14:16 18:20	8-10:1 16:18 20	classroom teachers at least a CDA, 1 EC special-ist with a BA	yes, depending on needs of program & staff person
NECPA	3:4E:1 6:8	3:5:1 6:8:10	4:1 8	4-6:1 8:10 12	7-10:1 14:16 18:20	8-10:1 16:18 20	at least 1/ctr with CDA+ 3yrs experience	30 clock hrs first yr, 24 thereafter based on need
COA	3:1 6	4:1 12	4:1 12	4:1 12	8:1 16	8:1 16	BA or certification in ECE	consultants available to staff
ACSI	4:1 none	6:1 none	8:1 none	8:1 none	10:1 none	12:1 none	lead teacher for each age group working on CDA	yes, center s Christian philosophy
NAFCC[1]	3:1[2] n.a.	4:1 n.a.	6:1 n.a.	6:1 n.a.	6:1 n.a	6:1 n.a	45 clock hrs	none

[1] Because there are mixed age groups in most family child care, NAFCC recommends ratios in terms of a maximum of 100 points for a small home provider, where babies = 30 points/child, older toddlers = 25 points/child, preschoolers = 15 points/child, and school-agers = 10 points/child.

[2] Age groups are defined differently as follows: babies and younger toddlers from 1-17 months, older toddlers from 18-35 months, preschoolers from 3-5 years, and school-ager from 6-12 years old.

Training Designs for Child Care Workers

Implementing the career development model developed by Wheelock College involves incorporating a career ladder into state child care licensing that is tied to a training system to qualify individuals for each successive wrung on the ladder. Instituting such a training system will require a culling of existing programs and increased oversight about the quality and content of approved courses and programs.

The child care field has developed effective training programs both for college students that prepare them for a career in the field and for child care workers to upgrade their skills and increase their opportunities for advancement. Both academic degree and adult education programs are needed. These programs need to be carefully articulated so that trainees can progress from adult education training programs to higher education degree programs that provide more general education and greater upward mobility. All of these programs need to combine classroom and on the job learning.

In addition to current needs to improve training, a major expansion of vouchers would increases the demand for child care workers, requiring an expansion in training programs. Fortunately, models exist that could be disseminated. We describe promising approaches to effective training and the expertise practitioners need to gain.

Bachelor of Science in Early Childhood Development and Education, University of Delaware[1]

Many universities and four-year colleges have introduced degree programs with majors in early childhood development and education. An exemplary program offered at the University of Delaware illustrates the scope of the knowledge base and the emphasis on field experience. This program is explicitly organized around the guidelines for early childhood teacher education developed by NAEYC. The curriculum for the major includes courses in human heredity and development, life span development, child development, family studies, community and family social services, the exceptional child, nutrition, literacy in young children, mathematics for elementary school, infant/toddler curriculum, preshool curriculum, assessment of young children, music for young children.

During the four-year program students build a portfolio recording their academic and field experiences and the student s reflections on these experiences. The program involves students in a sequence of field experiences beginning with observations of young children and culminating in two supervised seven-week student teaching placements. Settings for these field experiences represent high quality programs, reflect ethnic and cultural diversity and include children with disabilities. Through these experiences students adapt teaching strategies to developmental, individual and cultural patterns. By the time students graduate they are expected to have the knowledge, skills, and disposition to provide young children with growth-enhancing environments and to seek out resources to promote their continual professional development.

Learning Options Associates of Arts (AA) Degree

The National Association of Child Care Resource and Referral Agencies (NACCRRA) has created a distance learning option for child care workers called Learning Options.[2] One of the more ambitious programs available through Learning Options is an Associates of Arts Degree in early childhood education offered in cooperation with Nova Southeastern University. All courses are delivered via the Internet. The curriculum includes courses in child development, creating a developmentally appropriate curriculum, the exceptional child,

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[1] For more information contact the Department of Individual and Family Studies, College of Human Resources, Education and Public Policy, University of Delaware, Newark, DE 17716.

[2] Other courses offered through Learning Options include an adult basic education GED preparation course, a twenty (clock) hour course that meets the Washington state training requirements for new family child care providers and can be applied towards the Child Development Accreditation (CDA) credential, an introduction to the business of family child care, and a training course to prepare resource and referral agency family counselors. More information about programs can be found on its website: www.learningoptions.org or through the NACCRRA offices in Washington, D. C.

developmentally appropriate language and learning for young children, appraising children s growth, organizing learning environments, policy and politics in early childhood education. Learning Options also includes a number of credentialing courses, including a National Administrators Certificate created by the National Child Care Association.

The Child Development Associate Credential (CDA)

This nationally recognized program administered by the Council for Early Childhood Professional Recognition is the longest standing specially designed training program for child care workers.[3] In existence since 1971, it was initially designed to offer an alternative to college training that would suit the needs of Head Start staff. CDA candidates must meet competency standards in six areas of practice, complete 120 clock hours of formal child care education in specific subject areas offered by an appropriate agency and 480 clock hours of experience in a group setting. Candidates compile a portfolio that includes parent evaluation questionnaires, written examples of competence in the six competency areas, a collection of resource materials, and results of a formal observation by an ECE professional of the candidate working as a lead teacher in a state-approved child care setting. The Council then arranges a verification visit from a trained ECE professional who gives the candidate a written examination and an oral interview. The CDA credential could be the first step in a succession of increasingly formal credentials if academic programs were to give college credit for work completed in the CDA.

The Wheelock College Child Care Careers Program (CCCP)

Many states are encouraging welfare mothers to take jobs in child care centers or to become family child care providers. Since entry level jobs in child care require little or no training or experience, taking these jobs can relegate these women to low-pay, dead-end jobs. However, some groups are running training programs to help poor women move into a career path in early care and education that can lead to reasonable earnings.

The Center for Career Development at Wheelock College has operated the Child Care Careers Program (CCCP) since 1989.[4] It is an eight month program in which graduates earn15 college credit hours and a certificate indicating they meet the Massachusetts requirements for child care teacher certification. The program starts with a two week orientation including visits to child care centers to begin to teach participants how to observe children in child care environments. Students receive credits for a supervised internship where they work 18 hours a week in an infant/toddler setting in the fall and a preschool room in the spring. They spend afternoons at Wheelock to complete nine additional hours of college credit in courses that include work on practical writing and literacy. (To boost writing skills students learn grammar and spelling, analyze texts, write, proofread their papers, and read them aloud for comments.) They also participate in a weekly field seminar where they discuss problems with faculty that arise in the fieldwork as well as issues of returning to school, managing family life, and going back to work. Graduates of CCCP can take a free course at Wheelock that qualifies for the next grade up in the Massachusetts certificate program, and they receive academic advising to encourage them to go on to get a bachelor s degree.

U.S. Department of Labor Bureau of Apprenticeship Child Development Specialist (ACDS) Program

The U.S. Department of Labor Bureau of Apprenticeship collaborates with state and local agencies to operate the Apprenticeship for Child Development Specialist (ACDS) program. In 2000 three states - Maine, Minnesota, and West Virginia - had registered programs in place. Eleven other states were funded to develop and pilot registered apprenticeship programs. The funded states include: Colorado, District of Columbia, Indiana, Iowa, Kansas, Nevada, New Hampshire, New York, Vermont, Washington, and Wisconsin.[5]

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[3] Council for Early Childhood Professional Recognition, *The Child Development Associate Assessment System and Competency Standards: Preschool Caregivers in Center-Based Programs* (Washington DC: The Council for Early Childhood Professional Recognition, 1996).

[4] For more information on this program contact Patty Hnatiuk, Director of the Child Care Training Programs, Wheelock College, Boston, MA.

[5] Gwen Morgan and Sheri L. Azer, *Trends in Child Care Licensing and Regulation: 2000* (Boston MA: The Center for Career Development in Early Care and Education at Wheelock College, 2000).

The West Virginia program provides entry level training for people already working in early care and education. Based on the CDA competency goals, the apprentice completes 300 hours of classroom instruction over four semesters consisting of three hours of class time and a comparable amount of time in laboratory work each week. Concurrently, the apprentice completes 4000 hours of on-the-job experience supervised by the course instructor and work site supervisor. Graduates of the program receive a nationally recognized Child Development Specialist credential from the U.S. Department of Labor, and are ready to apply for the CDA credential. They can apply about 33 credit hours toward an associates degree in applied science at most state junior colleges. In turn, the 64 credit hours of the associates degree can be applied to a four-year Regents degree at some state colleges and universities. The Regents degree is a non-traditional degree allowing credit for work experience and relevant training. Directors of child care programs involved in the ACDS program agree to increase the participant s wages upon award of the credential.[6]

Management/Leadership Training

A particular weakness in child care training has been the lack of training specifically geared for directors. Although directors of ECE programs are well educated, 78 percent have B.A. s and 38 percent have M.A.degrees, most directors move into their jobs through promotion from the teaching staff. Their training and experience in teaching does not prepare them for leading and managing. Research on the causes of director stress, burn-out, and turnover among directors have identified lack of job definition, stress over personnel-oriented tasks of finding qualified staff, and lack of position-specific training as major factors affecting burn out.[7]

Corporate chains provide some in-house management training. Children s World Learning Centers, a nationwide child care provider with over 500 programs in 21 states, instituted a management training program in 1989 and found that within a year of instituting the program, both director and customer turnover dropped 5 percent, convincing management of the value of the training.

Several approaches to director training are now being developed.[8] Director support groups and mentoring programs aim at reducing the isolation of center directors and represent a compromise between traditional inservice training and supervision models. In the California Early Childhood Mentor Program paid director mentors with considerable management experience pair up with a new director to provide support through an established system organized around a coach/consultant relationship. In addition to the training involved, the program gives director mentors another avenue for career advancement. More formal graduate degree programs and summer workshops have also been designed to provide leadership and management training. Also, in 2000, 15 states were developing a director credential, and four of these states will require them by 2003.[9]

More formal graduate degree programs and summer workshops have also been designed to provide leadership and management training. One interesting master s degree program at Carnegie Mellon University has been designed to include both early care and education directors and elementary school principals in the same degree program. It offers graduate training in organizational theory, leadership styles, staff development, administration, community relations, and group dynamics. In studying core management skills together, they learn the similarities in management responsibilities across types of educational structures, hopefully, giving increased respect for the work of early childhood agencies.

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[6] For more information contact Apprenticeship for Child Development Specialists, River Valley Child Development Services, Huntington, West Virginia.

[7] Marsha Poster and Roger Neugebauer, Innovative Ideas from the Field, in Mary L. Culkin, ed., *Managing Quality in Young Children s Programs: the Leader s Role* (New York: Teachers College Press, Columbia University, 1999).

[8] These examples come mainly from Poster and Neugebauer, Innovative Ideas From the Field.

[9] Morgan and Azer, "Trends in Child Care Licensing and Regulation."